

**Pinellas Pain and Palliative Care**

2288 Drew St Suite C Clearwater FL 33765

Phone (727) 900-5533 Fax (727) 255-5853

UNIVERSAL PATIENT AUTHORIZATION FORM TO DISCLOSE CONFIDENTIAL HEALTH INFORMATION

FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE \*\*\*PLEASE READ THE ENTIRE FORM, BEFORE SIGNING BELOW\*\*\* Patient (name and information of person whose health information is being disclosed):

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment. By signing this form, I voluntarily authorize, give my permission and allow use and disclosure: OF ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

I AUTHORIZE \_\_\_\_\_ TO DISCLOSE HEALTH INFORMATION TO: DR WILLIAMS/ PINELLAS PAIN AND PALLIATIVE CARE

Phone: (727) 900-5533 Fax: (727) 255-5853

Address: 2288 Drew St Suite C Clearwater, FL 33765

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients. EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission. REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above. In addition: • I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. • I understand that there are some circumstances in which this information may be redisclosed to other • I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. • I have read all pages of this form and agree to the disclosures above.

Signature of Patient or Patient’s Legal Representative \_\_\_\_\_

Date Signed \_\_\_\_\_ Print Name of Legal Representative (if applicable) \_\_\_\_\_

Witness Print name \_\_\_\_\_ Witness Signature \_\_\_\_\_

You are entitled to get a copy of this form after you sign it.